

Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability (Form and Notice Procedures)

This form, including the “Procedures for notice of other coverage, Medicare entitlement, or cessation of disability” section, is part of the *PEBB Continuation of Coverage Election Notice*. For more information about this form, the PEBB’s notice procedures, and your COBRA rights and obligations, consult the *Summary Plan Description of Continuation Coverage Rights Under COBRA and PEBB Rules* and the other sections of the *PEBB Continuation of Coverage Election Notice*. These documents are available by calling PEBB Benefit Services at 1-800-200-1004.

When to use this form

Use this form when any of the following events occurs:

- A qualified beneficiary, after electing COBRA, becomes covered under other group health coverage (but only after any preexisting condition exclusions of the other plan have been exhausted);
- A qualified beneficiary, after electing COBRA, becomes entitled to Medicare (Part A, Part B, or both); or
- The Social Security Administration determines that a disabled qualified beneficiary is no longer disabled, if the maximum period of COBRA coverage previously was extended due to the qualified beneficiary’s disability.

Deadline	If you are providing notice of:	The deadline for this notice is:
	Other coverage (a qualified beneficiary, after electing COBRA or PEBB Extension of Coverage, becomes covered by other group health plan coverage)	60 days after the other coverage becomes effective or, if later, 60 days after exhaustion or satisfaction of any preexisting condition exclusions for a preexisting condition of the qualified beneficiary
	Medicare entitlement (a qualified beneficiary, after electing COBRA , PEBB Extension of Coverage, or PEBB-Sponsored Retiree Coverage becomes entitled to Medicare Part A, Part B, or both)	60 days after the beginning of Medicare entitlement (a copy of the Medicare card must be sent with this notice)
	Cessation of disability (a Social Security Administration determination that a qualified beneficiary is no longer disabled)	60 days after the date of the Social Security Administration’s determination (a copy of the Social Security Administration’s determination letter must be sent with this notice)

Procedures for notice of other coverage, Medicare entitlement, or cessation of disability

How to provide notice

Your notice **must** be in writing (using the PEBB form included in this notice) and either mailed or hand-delivered. Oral notice (in person or by telephone) and electronic notice (fax or e-mail) is not acceptable.

Where to provide notice

Mailing address

Health Care Authority
PEBB Benefit Services
P.O. Box 42684
Olympia, WA 98504-2684

Street address (for hand deliveries)

Health Care Authority
PEBB Benefit Services
676 Woodland Square Loop SE
Lacey, WA 98503

If mailed, your notice must be postmarked no later than the deadline described on the first page of this notice. If hand-delivered, your notice must be received by PEBB Benefit Services at the address above no later than the deadline described on the first page of this notice.

This contact information may change from time to time. The most recent contact information will be included in the PEBB's current *Summary Plan Description of Continuation Coverage Rights Under COBRA and PEBB Rules* or by calling PEBB Benefit Services at 1-800-200-1004.

Required form and information

You must use the *Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability* form to notify PEBB Benefit Services of any of these events. All of the applicable items on the form must be completed.

Additional information required for certain notices

- If you are providing **notice of other coverage**, your notice should include evidence of the effective date of other coverage (such as a copy of the insurance card or application for coverage).
- If you are providing **notice of Medicare entitlement**, your notice must include a copy of the Medicare card showing the date of Medicare entitlement before your premiums will reflect the Medicare rate.
- If you are providing **notice of cessation of disability**, your notice must include a copy of the Social Security Administration's determination that the qualified beneficiary is no longer disabled.

Who may provide notice

The employee or former employee who is or was covered under PEBB coverage, a qualified beneficiary (with respect to the qualifying event), or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries with respect to the other coverage, Medicare entitlement, or cessation of disability reported in the notice.

COBRA coverage will terminate regardless of whether or when notice is provided

If a qualified beneficiary first becomes covered by other group health coverage after electing COBRA or PEBB Extension of Coverage, that qualified beneficiary's continuation coverage will terminate (retroactively if applicable) as described in the *Summary Plan Description of Continuation Coverage Rights Under COBRA and PEBB Rules*, regardless of whether or when notice of other coverage is provided.

If a qualified beneficiary first becomes entitled to Medicare Part A, Part B, or both after electing COBRA, that qualified beneficiary's COBRA coverage will terminate (retroactively if applicable) as described in the *Summary Plan Description of Continuation Coverage Rights Under COBRA and PEBB Rules*, regardless of whether or when notice of Medicare entitlement is provided.

If a disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled, continuation coverage for all qualified beneficiaries whose COBRA coverage is extended due to the disability will terminate (retroactively if applicable) as described in the *Summary Plan Description of Continuation Coverage Rights Under COBRA and PEBB Rules*, regardless of whether or when notice of cessation of disability is provided.

If one of the events listed in this notice occurs (except entitlement to Medicare), COBRA coverage will be terminated (retroactively if applicable) as described in the *Summary Plan Description of Continuation Coverage Rights Under COBRA and PEBB Rules*, regardless of whether or when notice of other coverage, Medicare entitlement, or cessation of disability is provided. You are liable for repayment of all benefits paid after the termination date.



Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability

■ Type or print clearly in black ink.

Identify the employee or retiree who was covered under PEBB coverage

Print name of employee	Social security number
Print name of retiree	Social security number

Address of employee or retiree

Identify the initial qualifying event

Initial qualifying event	Date of initial qualifying event
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Event description (check one and complete)

Qualified beneficiary has become covered by other group health coverage after electing COBRA or PEBB Extension of Coverage

Print name of qualified beneficiary(ies)

Is the address of qualified beneficiary(ies) the same as the employee or retiree? (check one) Yes No If different, provide below

Qualified beneficiary has become entitled to Medicare after electing COBRA, PEBB Extension of Coverage, or PEBB-sponsored retiree coverage

Print name of qualified beneficiary(ies) who became entitled to Medicare

Is the address of qualified beneficiary(ies) the same as the employee or retiree? (check one) Yes No If different, provide below

Date Medicare entitlement began for Part A _____ Part B _____

A copy of the qualified beneficiary's Medicare card is required with this notice.

Qualified beneficiary ceased to be disabled

Print name of qualified beneficiary

Is the address of qualified beneficiary(ies) the same as the employee or retiree? (check one) Yes No If different, provide below

Date disability ended (according to Social Security Administration's determination)

A copy of the Social Security Administration's determination is required with this notice.

Certification, signature, and date

I certify that the above information is true and correct.

I am the (check one): Former employee or retiree

Spouse or former spouse

Qualified same-sex domestic partner or former qualified same-sex domestic partner

Former dependent child

Other (explain) _____

Signature

Date

Print Name

Telephone number

Address

Please sign and date this form.

Return to: Washington State Health Care Authority, PEBB Benefit Services, P.O. Box 42684, Olympia, WA 98504-2684

Washington State law may require disclosure of any information you submit as a public record.
The HCA's Privacy Notice is available upon request by calling 360-923-2822 or online at www.hca.wa.gov.

Visit our Web site at www.pebb.hca.wa.gov

For HCA Use Only

Date notice received _____ Date of postmark, if mailed _____

Type of continuation coverage _____ Election date _____

Evidence of effective date of other coverage enclosed? Yes No N/A

Copy of Medicare card enclosed? Yes No N/A

Social Security determination enclosed? Yes No N/A